

VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

☒ DT ☒ Id ☒ Tdap ☒ DTaP ☒ DTaP/Hep/EIPV ☒ Hib ☒ Polio ☒ HepA ☒ HepB ☒ HepB/Hib ☒ MMR
☒ MMR-V ☒ Rotavirus ☒ Varicella ☒ Pneumo Conj ☒ Pneumo Poly ☒ Meningo ☒ Influenza ☒ Other _____

Signature of Patient or Parent/Guardian

Date

PATIENT INFORMATION						
Patient's Last Name:		Patient's First Name:		Phone Number:	Age:	Birth date:
Street Address:			City:	County:	State:	Zip Code:
Ethnicity: Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: (Select one or more.) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> AS-Asian/Pacific Islander/Other <input type="checkbox"/> BL-Black or African American <input type="checkbox"/> CA-Caucasian/Mexican/Puerto Rican <input type="checkbox"/> CH-Chinese <input type="checkbox"/> FI-Filipino </div> <div style="width: 50%;"> <input type="checkbox"/> HA-Hawaiian <input type="checkbox"/> IN-Native American/Alaska Native <input type="checkbox"/> JA-Japanese <input type="checkbox"/> NW-Other Non-White <input type="checkbox"/> UN-Unknown </div> </div>				
Primary Care Physician:		Street Address: City:		State: Zip:	Phone: Fax:	
PATIENT ELIGIBILITY						
<input type="checkbox"/> Medicaid	<input type="checkbox"/> No health insurance	<input type="checkbox"/> Native Am/Alaska Native	<input type="checkbox"/> Underinsured**^	<input type="checkbox"/> Underserved**^	<input type="checkbox"/> HealthWave	<input type="checkbox"/> Fully Insured

*Underinsured children: insurance does not cover immunizations, are eligible through VFC program if vaccinated at a FQHC or RHC.

**Underserved children: children have insurance co-pay or deductible high enough to provide a barrier to immunizations.

^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	__yes __no
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	__yes __no
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	__yes __no
4. Has the person to be vaccinated had a seizure or other neurological problem?	__yes __no
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	__yes __no
6. Does the person to be vaccinated have close, regular contact with someone who has a weakened immune system?	__yes __no
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	__yes __no
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	__yes __no
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	__yes __no

NAME_____

AGE_____

DOB_____

PROVIDER INFORMATION

Vaccine Provider:

Clinic Site:

Street Address:

State:

Zip Code:

Street Address:

State:

Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
DTaP DT Td Tdap	1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib	4	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/EIPV	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
EIPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ			
Hep A	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B/Hib	1 2 3	RT LT	Deltoid Vastus Lat	IM			
MMR	1 2	RT LT	Upper Arm Thigh	SQ			
MMR-V	1 2	RT LT	Upper Arm Thigh	SQ			
Rotavirus	1 2 3		By Mouth	Oral			
Varicella	1 2	RT LT	Upper Arm Thigh	SQ			
PCV7	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
PPV23	1 2	RT LT	Deltoid Vastus Lat	IM			
MCV4	1	RT LT	Deltoid	IM			
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM			
Other							
Other							

Signature and Title of Vaccine Administrator

Date